Version 9

Abstract

Background: During the COVID-19 pandemic it was critical that service delivery was adapted to meet the demand. This qualitative study explored the experiences of Community Palliative Care Team staff as the service adapted.

Aim: To explore the experience of the Clinical Nurse Specialist (CNS) team during the Covid-19 pandemic.

Methods: Semi-structured interviews via a virtual platform.

Findings: Four themes were identified, service development, communication, inter-professional relationships and support mechanisms. The participants supported the change in service delivery and use of technology to triage patients. Improved collaboration and patient care co-ordination was reported. Enhanced support mechanisms used by the team helped sustain resilience and wellbeing.

Conclusion: This study provided insight into the experiences of a CNS palliative care team during the COVID-19 pandemic. Although challenging, the team embraced the changes and described improved collaboration and coordination of patient care.

Key Words: Covid-19, palliative care, Inter-professional working, Community, virtual ward, technology

Introduction:

Covid-19 was declared a pandemic by the World Health Organization (WHO) in March 2020 (WHO, 2020), which led to increased demand for healthcare services and significant changes within those services to manage the impact of prioritising clinical demand, and adapting practices against service needs (Al-Jabir *et al*., 2020).

The pandemic's impact on primary care raised concerns, particularly for the two-week cancer referral pathway. This was offset by increased emergency service attendance and emerging evidence of delayed cancer diagnosis with related mortality (Flynn *et al*., 2020). Predictions were made highlighting the potential increased impact on palliative care services as changes on survival and prognosis became evident with treatment options reduced or at worst no longer an option (Maringe *et al*., 2020).

Background

The challenge of meeting palliative care demand resulting from the pandemic reflected known workforce shortages but also recognition of the need for improvement in collaborative working for community services (The Kings Fund, 2018; The Kings Fund 2019). Suggestions to manage demand had predominately encouraged increased inter-professional working and more support to generalist services from specialist palliative care (SPC) services (Finlay, 2009; Rowlands *et al*., 2012) but without an agreed model of delivery (Etkind et al., 2017; NHS England 2019., The Kings Fund, 2019). It was recognised that as demand for SPC services increased, they would have to adapt to meet it (Etkind, 2019, Kamal *et al*., 2019,) Adapting to the new way of working increased pressure on the local Clinical Nurse Specialist (CNS) palliative care service which had already experience the pressures of a 52% in service requirement over the previous 5 years with further challenge anticipated aligning to the NHS Long Term Plan (2019). Swift changes had to be implemented within the CNS service to cope with both the real and anticipated demand for care. This included the creation of a coordination hub for managing palliative and end of life care patients and working more creatively and collaboratively with other local healthcare teams. It brought forward the thinking that having both the nursing and allied health professionals working alongside each other as one team would increase capacity and improve resilience. In addition a virtual ward (Ferry *et al.,* 2021) was created enabling the healthcare professional to attend to both personal care and nursing needs.

Consultation with patients in primary and community care services has historically been face-to-face however, telephone/video consultation became an option during the pandemic, if appropriate, in order to provide services whilst managing risk (GMC, 2020; NICE, 2020; RCN 2020). Telemedicine was introduced by the CNS team to support changes in practice and has resulted in many positive outcomes (Perrin, 2020).

Aim of Study:

The study aim was to understand the experience of the CNS team following implementation of new working practices during the pandemic.

Method

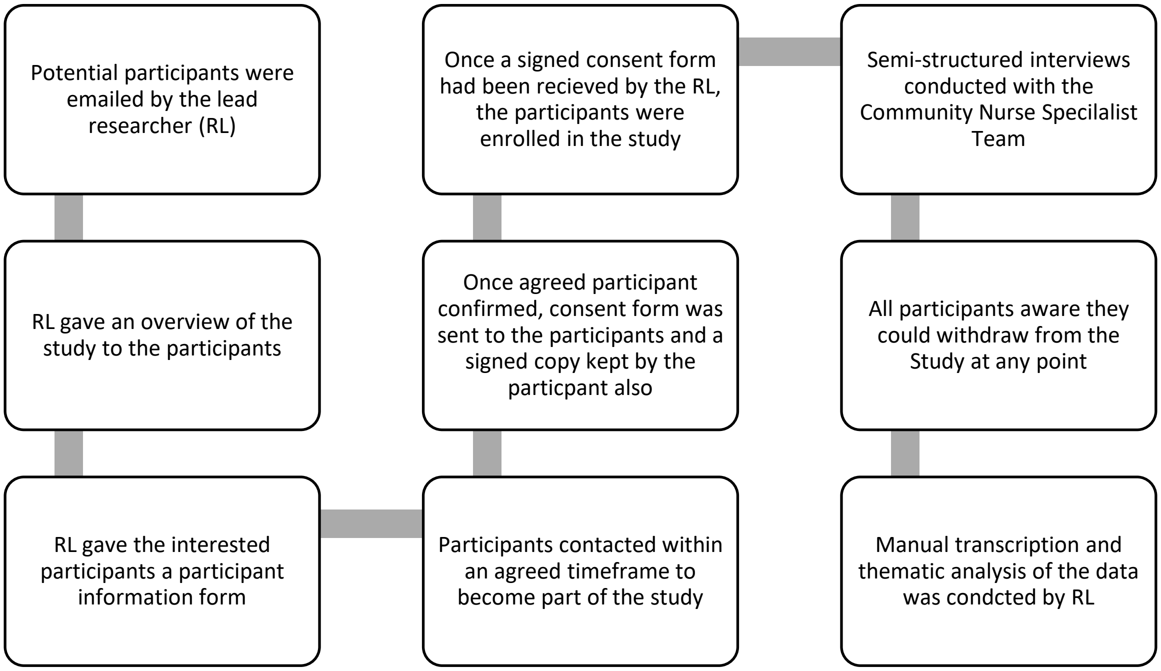
Design

A phenomenological approach, as defined by Bryman (2016), was used to inform the study's design, and semi-structured interviews were used to obtain detailed accounts from individuals about their experiences.

Participants and data collection:

Following ethical approval, a purposive sample of 12 CNSs were recruited; 11 participated one declined due to staff illness (Figure 1).

Figure 1 Recruitment and Consent process



Semi-structured interviews were conducted via Microsoft Teams using a schedule of nine questions reflecting the study objectives (see Table1)

Table 1. Interview Schedule:

1	Can you tell me your experience of working through the pandemic?
2	What changes in your working environment were implemented as a pandemic response?
3	What changes do you think relating to your working practice may have had a positive influence on patient care?
4	What changes from your perspective have had a positive influence on support to partners (Health and Social care) also providing healthcare?
5	What changes have you observed that may not have had a positive effect?
6	How do you think the use of technology has influenced patient care and support to partners? What was good? What was not good?
7	What is your experience of team collaboration throughout the pandemic response?
8	What support mechanisms that were available did you use to help maintain your resilience during this time?
9	Is there anything else you can add to describe your experience working in the team throughout the pandemic response?

The nursing and CNS experience of participants varied widely with nursing experience varying from thirty two to six years and CNS experience from sixteen to two years.

Data collection took place between June – August 2021, all interviews were conducted by the lead researcher.

Data Analysis:

Data were analysed using the framework developed by the National Centre for Social Research (Ritchie and Lewis, 2003). All interviews were transcribed verbatim and returned to the participant to confirm it was an accurate record of the interview. Minor revisions were made as requested. The transcripts were coded manually separately and an agreed thematic framework was established revisiting the study aim and objective.

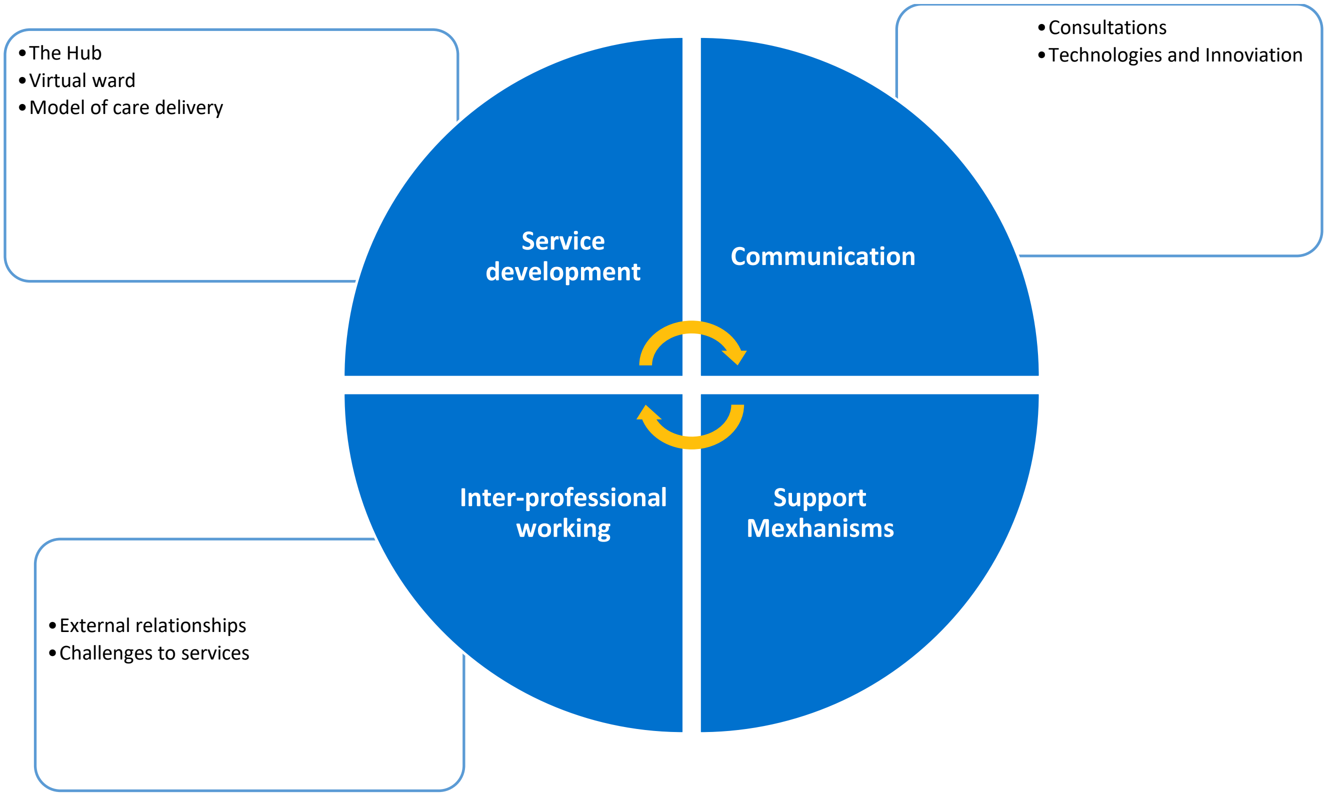
Ethical Considerations:

The study received ethical approval from a local research ethics committee. The researchers ensured they upheld the domains of the Research Governance Framework (Health Research Authority, 2021) and adhered to the principles of the General Data Protection Regulation (2018).

Findings:

Four main themes emerged:

- Service Development
- Communication
- Inter-professional Working
- Support Mechanisms



1. Service Development

This related to the rapid changes implemented to the community team as part of the pandemic response. Many participants described the impact of the changes which included both positive and challenging elements. Subthemes became evident:

The Hub

The creation of the coordination hub was mentioned positively and consistently by all participants. The hub provide a coordination centre for local end-of-life care, included a logistics service and became a central point of contact for all services providing a lead in the collaboration of services.

> *“We had had the vision for the hub for 2 years and it was pulled together in 5 days. We were moved in a direction of setting up something quite spectacular.”* (P2)
>
> *“The hub logistics was also set up using volunteers….they were able to go out and deliver medications, take out equipment and support the team (P6).*
>
> *Multidisciplinary working had a positive influence on patient care because we were working alongside each other in the hub, we had a much greater appreciation of each other’s roles and workloads.*” *(P4)*

Virtual Ward

The virtual ward was integral to the hub and end-of-life care provision. The aim was enhanced holistic care providing nursing and personal care to patients within their home by either a nurse or a health care assistant. It also supported the activity of the local District Nursing teams, hospital discharges to the community, which enabled people to die at home rather than be admitted to hospital or a hospice. The participants commented:

“Nurses and Health care Assistants worked together and a lot of the visits were allocated for the virtual ward. By working alongside the CHCA the CNS could administer medications before care and also offer support to the family.” (P3)

The virtual ward was also commented upon in raising awareness of Hospice services but raised challenges that this could also present,

“The virtual ward raised the awareness of what we (CNS) were able to do. I think other health care professionals such as DN, GP’s now acknowledge much more what we can deliver in terms of our skill sets and understand we can offer more specialist palliative care needs.”(P9)

Model of Care Delivery

Care delivery changed from CNS case load management with planned visits and contacts with support of a 24 hour helpline for reactive needs. The model was described by the participants as having advantages and disadvantages.

One said, “ working from a reactive model and focusing on having the right nurse, in the right place at the right time is more effective than working from a case load and means the right ‘team’ is allocated which often extends to the DN/React teams ” (P8)

Another said; “I think we were having to address a lot of conversations relating to advance care planning, we could be the first service to visit and address this, difficult conversations and implementing interventions rapidly was challenging at times.”(P7)

2: Communication

Communicating is always challenging, this theme explored factors considered by the CNS when communicating with patients, including consultations underpinned through technology and innovation. There were two subthemes:

Consultations:

The CNS team adapted from a predominately face-to-face service to primarily telephone/video consultations with face-to-face visits triaged following risk assessment. Home visits were agreed with patients as many were shielding.

Participants suggested:

“ We are much more skilled in assessment by telephone and video links now, you have to rely on honed assessment skills to ensure you have extrapolated all the information to inform the management plan” (P9)

“A benefit of using video assessment was other family members and other services such as GP’s could join the consultation regardless of where the patient lived geographically. It enabled first hand communication” (P1)

Some described how patients and their families were worried about home visits.

“What I found was some people did not want to have a CNS visit their homes and would ask for telephone assessment” (P1)

“People were scared of having people into their home environment so using telephone and video consultations met their needs” (P3)

Another suggested the use of technology was challenging in some circumstances

“Video technology was not always easy for our elderly patients. It was very good when it worked but it did cause anxieties for some patients ” (P5)

Technology and Innovation

The use of technology and examples of innovation was raised by participants. The hub was coordinated using a dedicated hub document supporting all aspects of coordinated service delivery and using MS Teams.

Some suggested;

"Our hub doc had started as a basic document then became a live and interactive interface that showed calls in/out/waiting together with visits allocated to all MDT including the virtual ward." (P11)

"Using Teams has transformed our ways of working. We use it to have a daily coordination meeting at 9.15am which supports the work for the day and brings everyone together as a team."(P4)

"Training has been able to continue through utilizing MS teams as the method of delivery and allowed for continual staff development" (P9)

3: Inter-professional working

The pandemic response demanded collaboration to ensure most appropriate service delivered patient care and staffing challenges were shared.

External relationships

Participants suggested relationships with other services, particularly the DN team, were stronger as a result of greater collaborative working, which also reflected greater understanding of roles.

"Before the pandemic we worked in silos with each service delivering independently, working more collaboratively has ensured we do not duplicate work, we took on additional tasks such as fast track that were previously completed by the DN's, this improved the delivery of care with one visit rather than multiple visits" (P1)

"Our relationships with the DN teams have really improved. We understand their role more and they do ours" (P6)

It was evident that everyone used peer support from an organizational perspective and from the wider community team.

“ We always supported each other, working collaboratively with internal teams, making sure people isolating or shielding were always included, we pulled together and in a weird way within a difficult time it has been a positive experience” (P10)

Challenges to services

Challenges included the sense that other services were not as accessible compared to pre-pandemic, such that participants reflected on needing to call on skills not utilised for some time if at all, or develop new ones.

They suggested;

“I felt we were impacted by changes to other primary services it felt overwhelming at times, we never say it’s not our problem – we will make a plan together and work to solve any problems or concerns (P6)

“Often when I visited a patient I was the first to see them for months, they were often at advanced stages of illness-had no support of oncology services. I felt my clinical skills had to be sharp, using my assessment skills in ways I had not been called upon to do before.” (P5)

4: Support mechanisms

This explored the mechanisms that supported participants as they worked through the pandemic. Participants spoke about the emotional impact of the work with fears for patients, colleagues, their families and themselves with increased responsibility to patient care when resources were significantly stretched.

They said, “It was scary, the awareness it would affect my work, potentially myself and family, colleagues, we were all scared as healthcare professionals as we were more exposed from our working environment as we remained patient facing.” (P1)

*“The overall impact affected every aspect of our lives professionally and personally affecting family relationships due to isolating and schooling for our children. We all had personal fear and anxiety of the threat of testing positive and the potential impact this would have on patient care“ (P*4)

Another reflected on the impact Covid had as a knock-on effect to patient care

“For me personally, what I have found the most difficult was patients who could have had earlier treatment intervention, they did not get access to it and therefore deteriorated more quickly.” (P9)

Several mechanisms were used to help maintain resilience including personal, peer and community support. Fears experienced by the team were balanced by the support from multiple agencies.

“The whole team has been very supportive of each other from Consultants, Team Leaders and other colleagues. We used each other to debrief, I didn’t feel there was a hierarchy and I was confident to ask for support from any team member.” (P3)

Another comment related to the reduction in social interaction resulting from new working practices,

“Social interaction was reduced as we had to change the way we worked. We had to maintain a 2 metre distance from one another, you could not physically support a distressed colleague.” (P1)

Others recognised the need to have personal time to help maintain resilience:

“With so much happening the temptation to log in and read emails on your days to keep up to date was tempting. However, you had to stop and take time away from work to look after yourself, taking time with family and being outdoors helped me.” (P6)

Discussion

The impact of COVID-19 was challenging and it was important that a co-ordinated approach was developed to support the increasing impact expected in an SPC setting (Bone *et al*., 2018; Hewison *et al.,* 2021). There were no defined frameworks for community palliative care provision within a pandemic/epidemic (Etkind *et al*., 2020; Mitchell *et al*., 2020) however, collaborative models were advocated enabling community palliative care services to develop and provide the necessary support to patients. In response to pandemic-related increased palliative care need, a community co-ordination hub was developed reflecting the requirements and aspirations of The NHS Long Term Plan (2019) and The Kings Fund Community Plan (2019). These plans suggest that without service collaboration, demand for future palliative care needs would be difficult to meet whilst also recognising the challenges. Whilst one of the most challenging objectives for health care is to reduce inappropriate hospital admissions, the need for complex patient management in primary care has received less policy attention both in the UK and globally (Park *et al.,* 2020) The pandemic forced the discussion to drive services forward collaboratively and the CNS team supported the need for coordination of services, which was brought forward because of the pandemic. Locally a co-ordination hub model based on the concept of a 'Virtual Ward' was developed, which contributed significantly towards optimizing patient care (Schultz, *et al.,* 2020). The virtual ward model was chosen as previous research has shown it can reduce hospital admissions and offer the clinical support of a hospital environment within the patient's home as teams work together to meet the patient's needs (NHS, 2021).

Throughout the pandemic the CNS team used the concept of the virtual ward by offering SPC reviews to optimize symptom management enabling the person to remain at home. This was endorsed by patients as they wanted to avoid hospital admission or other care settings due to fears of contracting Covid-19, and restrictions to visiting leaving people isolated and unable to see friends or family (RCN, 2021). Moreover participants reported that '*many patients did not ring because they did not want to let anyone into their home and only called when they had reached a crisis point'.* This was also reported from DN teams who felt patients were reluctant to allow home visiting for regular review (RCN, 2021). This often resulted in patient’s symptoms or social needs presenting at crisis due to infrequent monitoring (Smyrnakis *et al.,* 2021) as confirmed by the participants of this study. Participants also noted that some patients were reluctant to present to healthcare professionals and in some instances, this led to delayed diagnosis and presentation of advanced incurable disease and cancer deaths as predicted by Maringe *et al*. (2020).

Palliative care provision often enables complex and challenging decision making (Etkind *et al.,* 2020) and the needs for patients was mentioned by several participants as challenging, particularly, the need to ensure that Advance Care Plans (ACP) were in place (NICE, 2019). They linked the missed continuity of contacts with other health care professionals such as GPs to ACP conversations being missed. The findings from this study reflect a study of Denmark GPs who recognised the need for ACP but also encountered the more difficult situation of having to approach it without the grounding of an established relationship where the conversations had been built over time (Dujardin *et al*., 2021). However, whilst the recognition to facilitate ACP in a time of uncertainty was encouraged caution was communicated by NHS England and a joint statement from the GMC/NMC (NHS England, 2020; GMC and NMC, 2020) advising that ACPs should remain person-centered and individual.

Although the pandemic was challenging at times the participants reported improved working relationships with the wider teams especially DN teams. They suggested that this was achieved by the creation of the co-ordination Hub which triaged and coordinated patient need ensuring the right service attended. This brought about a more coordinated response and understanding of each other's roles and responsibilities. Primary care services changed during the pandemic with a reduction in GP consultations resulting in increased calls to the CNS service. However, participants suggested that the coordination hub and virtual ward raised the profile of the team positively with both the GPs and DNs.

Despite the challenges of continuing patient services during the pandemic participants described how maintaining resilience was vital for them and how important it was for them to take care of themselves. They described how '*ensuring time taken to go for walks, enjoying hobbies and time away from work'* helped to maintain their resilience as advocated by Duncan and Smart, (2021). The CNS team employed emotional regulation naturally as a response and appeared self-aware and proactive in managing this, however, this should not lead to complacency as the challenge is to sustain resilience and the momentum of self-care (Bennett *et al.,* 2020). Team support was also a significant component in maintaining resilience for them with several opportunities to debrief and share experiences as described as important by (Donnelly *et al.,* 2021; Villar *et al*., 2021). It was noted in the participant responses that 'Team' was not isolated to immediate, internal teams but the wider nursing teams including DN colleagues. Within this study staff working in leadership roles were described as supportive and some suggested that hierarchy was not a barrier and that they felt confident about accessing support if needed. Another form of support appreciated by the CNS team was being valued and appreciated through donations from the public and businesses which included food and practical gifts (Liu *et al*., 2020; Vindrola-Padros *et al.,* 2020).

Understanding the workforce pressures and demands is essential to ensure provision of support needed to maintain resilience and wellbeing.

Conclusion

The COVID-19 pandemic required innovative ways of working to be introduced. A community CNS palliative care team introduced a virtual hub and a virtual ward allowing for a coordinated collaborative partnership to providing patient care. Improved team work and understanding different community roles was seen as positive by participants. The CNS workload was reported as increasing due to changes in the provision of care by primary care. The use of technology to communicate with patients and colleagues was seen as imperative to the success of care delivery. Resilience was maintained by the wider team support and debrief sessions.

Key Points

- The use of technology including video consultation, virtual platforms for communication both inter-professionally and patient facing were embraced and positively adapted into working practice
- The creation of the coordination hub enhanced patient care and inter-professional working
- The positive outcome of enhanced inter-professional working between the CNS and DN teams allowed the model to move away from working in ‘silos’ which benefited patient need and service
- The impact of the pandemic increased the demand for palliative care services particularly to the 24 hour telephone support line

Reflective Questions

1. How can specialist palliative care services further support generalist services in the delivery of palliative care

2. How can inter-professional working relationships between organisations be facilitated and improved?
3. What are the benefits and challenges for using video technology for patient consultation

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